MOUNT SINAI SCHOOL OF MEDICINE

MOUNT SINAI GENETIC TESTING LABORATORY

Department of Genetics and Genomic Sciences
Mount Sinai School of Medicine

One Gustave L. Levy Place, Box 1497
New York, NY 10029-6574
Tel: 212-241-7518 Fax: 212-241-0139
CLIA # 33D0653419

Warfarin Genotyping Test Requisition

Call 212-241-7518 for pick up between and 9 AM and 4 PM

Patient's Name: _____DOB: ___/___/___
Last First
Patient Address: Street _____
City _____State _____Zip_____
Patient Telephone (Day) _____(Evening)_____
Referring Physician_____Telephone_____
Fax_____
Billing/Insurance Information
Name of Policyholder:_____
Insurance Carrier_____Ins ID_____Group#_____
Billing Address:_____
Other Health Coverage? (Identify):_____
Please attach copy of insurance card

Clinical information for warfarin pharmacogenetic testing.
Information required for calculating suggested warfarin dose. Algorithm incorporates the pharmacogenetic test results and the following clinical data.

Age: _____

Sex: _____

Race: _____

Ashkenazi Jewish: Yes___ No ____

Weight: _____lbs or _____kgs

Height: _____feet/inches or _____cms

Smokes: NO YES

Liver disease: NO YES

Indication: _____

Baseline INR, if already on Warfarin: _____

Target INR: _____

Amiodarone/Cordarone dose: _____mg/day

Statin/HMG CoA reductase inhibitor: which statin _____or no statin

Any Azole: NO YES

Sulfamethoxazole/Septra/Bactrim/Cotrim/Sulfatrim: NO YES

Informed consent is mandatory for warfarin pharmacogenetic testing.
Consent form supplied on the back.

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Genetic Testing Laboratory Informed Consent
Warfarin Pharmacogenetic Testing for Initial Dosing

I, _____, hereby request DNA-based testing for variations in genes that may affect my therapeutic warfarin dose. I have received verbal and/or written information from my physician or from a genetic counselor that described, in words that I understood, the nature of the genetic testing that I am about to undergo.

I understand that I am being tested for variations in two genes. These variations may affect the way I metabolize and respond to this anti-clotting drug. I will be classified as a standard or a more sensitive or a more resistant responder to warfarin.

This testing may allow my doctor to more effectively prescribe the initial warfarin dose for me. However, I do understand that this testing does not take into account non-genetic factors that may influence proper dosing and my doctor should interpret the results relative to my clinical situation.

The nature of DNA testing has been explained to me and the accuracy of the test and its limitations have been detailed. I understand that while results obtained from DNA testing are usually highly accurate, infrequent errors may occur. The likelihood of this occurring has been estimated to be less than 1%.

The results of the testing will be released only to the ordering physician as required by New York State law. The results will not be released to anyone else without my written authorization. The results of my test will be explained to me by my physician who will have the opportunity to discuss my results with a Biochemical/Molecular Geneticist or Genetic Counselor.

The sample (blood and DNA) will be kept for approximately 60 days after the testing is complete (as is acceptable in NYS CLIA-approved diagnostic laboratories), and then will be destroyed. This stored sample will be identifiable in that it will be labeled with my name and date of blood draw.

I have had the opportunity to have all of my questions answered. I understand that this consent is being obtained in order to protect my right to have all of my questions answered before testing. I also understand that the results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals who I designate to receive this information.

_____ _____
Signature of Person Being Tested *Date*

_____ _____
Signature of Witness *Date*